# DIABETIC MEDICAL MANAGEMENT PLAN

Student: _____ School Year_____ Today's Date: _____
Grade: _____ Homeroom Teacher: _____ DOB:_____
Allergies: _____Bus # AM _____ Bus #PM _____ Walker_____ Car rider _____
Physical condition: Diabetes Type 1_____ Diabetes Type 2_____ Date of diagnosis: _____
Injections/self: _____ Injections/assist: _____ Insulin Pump: _____ Type of pump: _____
Checks/self_____ Checks/ assist _____

## CONTACT INFORMATION

Mother/Guardian: _____home/cell _____ Work _____
Father/Guardian: _____home/cell _____ Work _____
Emergency contact: _____home/cell _____ Work _____
Emergency contact: _____home/cell _____ Work _____
Physician: _____ Phone:_____

**Blood Glucose Level (BGL) Target Range:** _____mg/dl **to** _____ mg/dl

**Notify parent/guardian if BGL < _____ or > _____ or in these situations:**

_____
_____
_____

## STUDENT'S COMPETENCE WITH PROCEDURES

*Please check all that apply and add an explanation or note if needed

| | PROCEDURE | Explanation/Notes | | PROCEDURE | Explanation/NOTES |
|---|---|---|---|---|---|
| | Blood Glucose Monitoring | | | Carry supplies for BG monitoring | |
| | Determines insulin dose for carbs eaten | | | Carry Supplies for insulin administration | |
| | Measuring insulin | | | Self-treat for mild lows | |
| | Injecting insulin | | | Disconnect or suspend pump | |
| | Operates pump independently | | | Monitor BG in classroom | |

***Parents are responsible for providing supplies.**
Students who do not have supplies
will not be allowed to remain at school.
This is for your child's safety.

**SUGGESTED SUPPLIES:**
Blood Glucose Meter, test strips & batteries
Lancet device, lancets, gloves, etc.
Urine ketone strips
Insulin Pump and supplies if applicable
Insulin pen, needles, and insulin cartridge
Fast-acting glucose source
Carbohydrate containing snack
Glucagon emergency kit

Student: _____ School Year_____ Today's Date: _____

## BLOOD GLUCOSE (BG) MONITORING (CHECKS)

| | | | |
|---|---|---|---|
| ❑ On arrival to school | ❑ Breakfast | ❑ After PE | ❑ PRN suspected low |
| ❑ Snack | ❑ Lunch | ❑ Before recess | ❑ PRN suspected high |
| ❑ Upon Dismissal | ❑ Before PE | ❑ After recess | ❑ Other_____ |

## INSULIN ADMINISTRATION

**DOSE DETERMINED BY:** ❑ Student ❑ Parent ❑ School Nurse
**INSULIN DELIVERY SYSTEM:** ❑ Pen ❑ Syringe ❑ Pump
**ADMINISTER INSULIN:** ❑ Before eating ❑ After Eating

**INSULIN to CARBOHYDRATE Ratio**: _____ Unit(s) per _____ grams carbohydrates

**INSULIN CORRECTIONS for high blood sugar:**

❑ Sliding scale (this is based on pre-meal BG check) ❑ No sliding scale

BG less than_____= subtract _____u
BG from _____ to _____ = _____u
BG from _____ to _____ = _____u
BG from _____ to _____ = _____u
BG from _____ to _____ = _____u
BG from _____ to _____ = _____u
BG from _____ to _____ = _____u

*Add the sliding scale insulin correction to the meal insulin for the **total** meal time insulin dose.

**Time of breakfast (if eaten at school)**_____
**Time of recess:**_____
**Time of lunch:** _____
**Days and times of PE:** _____
**Time of dismissal:**_____

**LOCATION of Supplies/Equipment:** (to be completed by school personnel)

| | | |
|---|---|---|
| Blood Glucose Equipment: | ❑ Clinic | ❑ With student |
| Insulin administration supplies: | ❑ Clinic | ❑ With student |
| Fast Acting Carbohydrates: | ❑ Clinic | ❑ With student |
| Snacks: | ❑ Clinic | ❑ With student |

**Glucagon Emergency kit:**_____**Ketone testing Supplies:**_____

Student: _____ School Year_____ Today's Date:_____

## MANAGEMENT of LOW Blood Glucose-Hypoglycemia

**MILD**: **Blood Glucose <** _____

- ❑ Never leave student alone
- ❑ Give 15 gms glucose; recheck in 15 min.
- ❑ Notify parent.

**SEVERE**: **Loss of Consciousness or seizure**

- ❑ Call for Nurse. Call 911. Open airway. Turn on side.
- ❑ **Glucagon injection** ❑0.050mg ❑1.0 mg IM/SQ
- ❑ Notify parent **injection site** ❑Arm ❑Thigh ❑Other

Student's Symptoms/Additional Notes :_____

_____

_____

## MANAGEMENT of HIGH Blood Glucose-Hyperglycemia

**Blood Glucose >** _____

- ❑ Water/Sugar-free fluids/frequent bathroom privelages
- ❑ Correct using sliding scale- if > 300 for 2hrs since last dose, give ❑HALF ❑FULL
  if > 300 for 4hrs since last dose , give ❑FULL
- ❑ Call parent for correction dose
- ❑ if > _____ check for ketones. Notify parent if ketones present.

Student's Symptoms/Additional Notes :_____

_____

_____

## EXERCISE

Faculty/staff must be informed and educated regarding management. Staff should provide easy access to fast-acting carbs/snacks and BG monitoring equipment. Child should **NOT** exercise if Blood Glucose levels are < 70 or > 300 and urine contains moderate or large ketones.

- ❑ Check BG right before PE/Recess to determine need for additional snack
- ❑ If BG, <70, drink or eat _____
- ❑ Student may disconnect /suspend insulin pump or decrease basal rate by _____.

My signature provides authorization for above orders. I give my permission to the school, to contact the physician , if necessary, to complete this plan. I understand that all procedures must be implemented within state laws and regulations.

- ❑ Dose/treatment changes may be relayed through parent

Parent_____Date_____ School Nurse_____Date_____

Physician_____Date_____ Principal_____Date_____